STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155761	B. WING		04/17/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R	2 E TI		
BROWN	SBURG MEADOW	S		/NSBURG, IN 46112	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
F0000	This visit was a State Licensur This visit include Complaint INO Unsubstantiate evidence.  Survey dates: 16 and 17, 200 Facility number Provider number AIM number: Survey team: Leia Alley, RN Patty Allen, BS Marcy Smith, Finah Jones, Finah	for Recertification and re survey. ded the Investigation of 0104573. 0104573-ed due to lack of  April 9, 10, 11, 12, 13, 12 er: 011367 per: 155761 200851590  , TC SW RN RN rpe:	F0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any any conclusion forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETT OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVIEW on or after May 17, 2012.	of ot ss n set n or N ER
	Total: 142				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: M9H911 Facility ID: 011367

TITLE

PRINTED: 05/15/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155761	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMP 04/17	E SURVEY LETED 7/2012	
	PROVIDER OR SUPPLIER SBURG MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE  2 E TILDEN  BROWNSBURG, IN 46112				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.					
	Quality review completed on April 23, 2012 by Bev Faulkner, R.N.					

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Facility ID: 011367

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155761	B. WINC			04/17/	2012
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			2 E TILI	DEN		
BROWNS	SBURG MEADOWS	3		BROWN	NSBURG, IN 46112		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0223 SS=D	SECLUSION	3(b)(1)(i) BUSE/INVOLUNTARY the right to be free from					
	verbal, sexual, p	hysical, and mental abuse, nent, and involuntary					
	sexual, or physic	not use verbal, mental, cal abuse, corporal nvoluntary seclusion.					
	•	•	F022	23	F223 1. What corrective		05/17/2012
	Based on recor	d review and			actions will be accomplished		
		acility failed to ensure			for those residents found to		
		vere free from abuse			have been affected by the		
		dents interviewed of			deficient practice? A meeti	ng	
		ided on the 400 Hall.			was held with Resident # 80. When asked if she has ever be	en .	
	(Resident # 80)				treated badly here she states	2011	
	(resident # 00)	,			"no". However, further discussi	on	
	Findings Includ	e:			reveals she thinks all males the work here are here for sexual reasons. We have added to he		
	On 4/10/2012 a	at 02:24 p.m., an			care plan she is not to have ma	ale	
	interview with F	Resident #80 indicated			caregivers if at all possible. Du		
	she had been t	reated roughly by a			to the fact this resident had no informed us of any prior conce	-	
	male staff mem	ber. Resident #80			with this issue, she was educa		
	indicated "Som	etimes the male CNAs			on how to report any complain		
	are rough." Sh	e indicated she			that she has. Resident states		
	believes one m	ale aide fondled her			sometimes she "just gets these		
	because he hel	ld her too closely to his			things in her head." She has be referred for counseling and	een	
		o long when he			psychological evaluation on thi	is	
	assisted in tran	sferring her from her			issue. During meeting residen		
	bed to her whe	elchair. She also			could not think or describe any	,	
	indicated one C	CNA came into her			other employee she is fearful of		
	room and indica	ated, "All you do is			and states she likes living here	<b>)</b> .	
		o." The Resident			Her psychological evaluation showed diagnosis of dementia		
		y blame me when the			parnoid personality disorder, ru		
	toilet stops up."	-			out delirium, and history of fals		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155761	A. BUI	LDING	NSTRUCTION 00	(X3) DATE SURV COMPLETEI <b>04/17/201</b>	D
	ROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE DEN NSBURG, IN 46112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ге	(X5) OMPLETION DATE
IAU	She indicated so CNAs working  4/12/12 at 10:1 facility's policy Prohibition, Re Investigation Produced February Executive Direct definition of abinfliction of injurconfinement, in punishment with harm or pain or includes deprivincluding a care services that all or maintain phypsychosocial with presumes that all residents, even	she is fearful of all the on the 400 Hall.  4 a.m., a review of the entitled "Abuse porting and olicy and Procedure," 2010, provided by the ctor indicated the use as, "the willful ry, unreasonable atimidation or the resulting physical result		1100	allegations.  2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. A resident interview has been developed and will be administered to assure no otheresidents feel this way.  Appropriate action according the policy will be taken if any otheresidents feel this way.  Appropriate action according the policy will be taken if any otheresidents are expressed.  3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Dure this interview process all residents will be informed on the to report any concern that they have to their customer service representative that is assigned them. The DNS and/or design will conduct a staff in-service cabuse, abuse prevention, and reporting of abuse on May 5 then. The DNS and/or design will conduct a staff in-service cabuse, abuse prevention, and reporting of abuse on May 5 then. The DNS and/or design will conduct a staff in-service cabuse, abuse prevention, and reporting of abuse on May 5 then. The DNS and/or design will conduct a staff in-service cabuse, abuse prevention, and reporting of abuse on May 5 then. The DNS and ongoing. During Resident council, there be additional discussion on how to voice any concerns to any sembler at any time. All new residents with will be informed how to report concerns through their customer service representative.  4. How the corrective actions will be monitored to ensure the deficient practice will not red	er  to  ing  now  to  to  will  w  taff  on  h	DAIL

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AND PLAN OF C	ORRECTION	IDENTIFICATION NUMBER:  155761	A. BUILDING  B. WING	00	(X3) DATE COMPI 04/17	
BROWNSBU	TIDER OR SUPPLIER	8	2 E TIL BROW	ADDRESS, CITY, STATE, ZIP CODE DEN NSBURG, IN 46112	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE PRIATE	(X5) COMPLETION DATE
				i.e., what quality assurance program will be put into put	place? DNS/ r QI tool, ly x 2  we see the CQI e ED. If chieved	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155761	A. BUII			04/17/	2012
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
DDOMN				2 E TILI			
BROWNS	SBURG MEADOWS			BROW	NSBURG, IN 46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0225	483.13(c)(1)(ii)-(	iii), (c)(2) - (4)				ï	
SS=D	INVESTIGATE/F	REPORT					
	ALLEGATIONS/						
		not employ individuals who					
		guilty of abusing,					
		istreating residents by a court					
		ad a finding entered into the					
		registry concerning abuse, tment of residents or					
	_	of their property; and report					
		t has of actions by a court of					
	, ,	mployee, which would					
		s for service as a nurse aide					
	or other facility s	taff to the State nurse aide					
	registry or licens						
	_	ensure that all alleged					
		ng mistreatment, neglect, or					
		injuries of unknown source					
		ation of resident property are					
		ately to the administrator of					
	-	o other officials in accordance					
		rough established uding to the State survey and					
	certification ager	-					
	oci illoation agei	10y).					
	The facility must	have evidence that all					
	•	s are thoroughly investigated,					
	-	nt further potential abuse					
	while the investi	gation is in progress.					
		investigations must be					
	•	dministrator or his					
		esentative and to other					
		dance with State law					
		State survey and certification					
		working days of the incident, d violation is verified					
		ective action must be taken.					
		souve action must be taken.	F02	25	F225 1. What corrective		05/17/2012
			1.02	43		ı	03/17/2012
	Based on interv	view and record			actions will be accomplished	1	
			1		for those residents found to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE S	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155761		LDING		04/17/	2012
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
DDOMAN				2 E TILI			
BROWN	SBURG MEADOWS			BROW	NSBURG, IN 46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	review, the faci	ility failed to report			have been affected by the		
	allegations of a	buse for 1 of 10			deficient practice? Resident	•	
	. •	viewed in a sample of			#80 has a long document		
	51 residing on	·			behavioral care plan for yelling		
	(Resident # 80				out in the dining room when sh		
	(INESIDEIIL# 00	)			wants something or yelling out when staff provides care/atten		
	Finalis .	L			to others. All staff have been	uon	
	Findings Includ	ie:			educated when she is yelling i	n	
					the dining room wanting	•	
	The record of F	Resident # 80 was			something they are to walk over	er	
	reviewed on 4/	13/2012 at 11:00 a.m.			to her table to respond instead		
					trying to answer her from acro	ss	
	A Social Service Progress Notes,				the room as she feels she is		
	dated 2/22/12,	•			being yelled back at and hurts		
	· ·	of an interview with			feelings. The SSA has comple		
					additional training on May 3, 2		
		by the SSA [Social			by the Executive Director on h	OW	
		tant]. Resident #80			to report, investigate, and document a complaint properly	,	
		le yelled at her and			2. How other residents havir		
	made her feel s	stupid. When asked if			the potential to be affected b	_	
	she wanted he	r (SSA) to talk to			the same deficient practice w	-	
	people, the res	ident indicated she did			be identified and what		
	not since she for	elt that would make the			correction actions will be		
	situation worse	•			taken? All residents have the	<b>;</b>	
		•			potential to be affected. The D	NS	
	On 4/17/12 at <sup>-</sup>	10:50 a.m. an			and/or designee will conduct a		
		,			staff in-service on abuse, abus	se	
		he Executive Director			prevention, and reporting of	ı	
		she was on vacation			abuse on May 5 th , 6 th , 15 th		
		esident spoke with the			2012 and ongoing. All potentia allegations of abuse will be	l <b>l</b>	
		g how "people yell at			reported timely to the Director	of	
	me and make r	me feel stupid" and			Nursing and Executive Director		
	was unaware c	of the interview. No			for investigation and reporting		
	investigation ha	ad been initiated of			our policy. 3. What measur		
	which she was				will be put into place or what		
					systemic changes will be ma	de	
	On 4/17/12 at <sup>-</sup>	12:30 n m an			to ensure that the deficient		
		•			practice does not recur? Any	/	
	i interview with t	he SSA indicated she					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIG	00	COMPL	ETED
		155761		LDING		04/17/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8		1			
DDOMAN				2 E TILI			
BROWN	SBURG MEADOWS			BROW	NSBURG, IN 46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	spoke with the	resident's nurse			grievance alleging abuse will b	oe .	
	regarding the r	esident's concern			investigated immediately per		
	about being yelled at, and requested				abuse protocol. Grievances wi		
	the staff not speak from across the				be daily by ED/Designee. The DNS and/or designee will cond		
	room but walk over to the resident				a staff in-service on abuse, ab		
	and speak to her closely so the				prevention, allegations of abus		
	•	•			and reporting of abuse on May		
	resident could hear what the staff was				th , 6 th , 15 th , 2012 and		
	saying.	ated she had			ongoing. All potential allegatio		
	The SSA indicated she had				of abuse will be reported timel	y to	
	completed a Resident/Family				the Director of Nursing and Executive Director for		
	Concern/Grievance Form, dated				investigation and reporting per	-	
	2/22/12, but had not followed up on				our policy. 4. How the		
	the complaint with her Supervisor or				corrective actions will be		
	ED.				monitored to ensure the		
					deficient practice will not rec	ur	
	When question	ed, the SSA was able			(i.e., what quality assurance		
	to quote the Fa	icility Policy on abuse			program will be put into plac		
	-	ng 5 types of abuse, to			To ensure compliance, the DN	IS/	
	•	suspicion of abuse			Designee is responsible for		
	-	port it (immediately).			completion of the abuse CQI to weekly x 4 weeks, bimonthly x		
		she did not follow up			months, and quarterly until	. 2	
		nember regarding			continued compliance is		
	resident compl	•			maintained for 2 consecutive		
	resident compi	ann.			quarters. The results of these		
	0 4/47/40 1	10.10			audits will be reviewed by the		
		12:40 p.m., the SSA			committee overseen by the ED		
	· ·	ied to the Director Of			threshold of 100% is not achie		
	Nursing's (DON	N) office to obtain the			an action plan will be develope to assure compliance.	ea	
	Grievance Forr	<ul> <li>The DON indicated</li> </ul>			to assure compliance.		
	she had just re	ceived the form and					
	did not have kr	nowledge of the					
		rance on 2/22/12					
	before 4/17/12 at 11:45 a.m. The						
		ed by the SSA but was					
	_	-					
		he Director of Social					
	I Services nor th	e Executive Director.					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER:  155761	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPLI <b>04/17</b> /	ETED		
	ROVIDER OR SUPPLIER SBURG MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE  2 E TILDEN  BROWNSBURG, IN 46112					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	The SSA acknowledged she had kept the form on her desk since 2/22/12 and had not followed up on Resident #80's allegation.						
	3.1-28(c) 3.1-28(e)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLETE			ETED	
		155761	B. WIN			04/17/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			2 E TILI			
BD∪WNI	SBURG MEADOWS	•			NSBURG, IN 46112		
BROWN	SBURG MEADOWS	9		BROW	NSBORG, IN 40112		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	483.13(c) DEVELOP/IMPL ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property. Based on record interview, the fatheir written policies ample of 51 resident #80  Findings Includ  On 4/13/12 at 1 record of Resident #80  Findings Includ  A Social Service dated 2/22/12,, documentation Resident #80 c. The resident incat her and mad When asked if	MENT ABUSE/NEGLECT,  develop and implement and procedures that prohibit eglect, and abuse of sappropriation of resident  ord review and acility failed to follow licy on reporting abuse dents interviewed in a esiding on the 400 Hall.  e:  11:00 a.m., the clinical lent # 80 was  be Progress Note, included of an interview with onducted by the SSA. dicated people yelled e her feel stupid. she wanted her (SSA)	F02	TAG	F226 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #80 has a long document behavioral care plan for yelling out in the dining room when shwants something or yelling out when staff provides care/attent to others. Her care plan was updated to show when she is yelling in the dining room want something staff are to walk owto her table to respond instead trying to answer her from acrost the room as she feels she is being yelled back at and hurts feelings. Her psychological evaluation showed diagnosis of dementia, parnoid personality disorder, rule out delirium, and history of false allegations. The SSA has completed additional training May 3, 2012 by the Executive Director on how to report,	ne tion ing er of ss her	DATE  05/17/2012
	to talk to people	-			investigate, and document a		
		id not since she felt			complaint properly. 2. How		
	that would mak	e the situation worse.			other residents having the	•	
	On 4/17/12 at 1	0:50 a.m., an			potential to be affected by the same deficient practice will be identified and what correction	е	
	interview with the	he Executive Director			actions will be taken? All		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155761	B. WIN			04/17/	2012
NAME OF I	DROVIDED OD SLIDDLIEE		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF			2 E TILI	DEN		
	SBURG MEADOWS	3		BROWN	NSBURG, IN 46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		she was on vacation			residents have the potential to affected. The DNS and/or	be	
		esident spoke with the			designee will conduct a staff		
	SSA concernin	g how "people yell at			in-service on abuse, abuse		
	me and make r	ne feel stupid" and			prevention, and reporting of		
	was unaware c	f the interview. No			abuse on May 5 th , 6 th , 15 th	h,	
	investigation ha	ad been initiated of			2012 and ongoing. All potentia	al	
	which she was				allegations of abuse will be	_	
					reported timely to the Director		
	On 4/17/12 at	12·30 n m an			Nursing and Executive Director		
		he SSA indicated she			for investigation and reporting our policy. 3. What measure		
	spoke with the nursing staff,				will be put into place or what		
	l •	_			systemic changes will be ma		
		esident's concern			to ensure that the deficient		
		lled at and requested			practice does not recur? Any	y	
		from across the room,			grievance alleging abuse will b	-	
	but walk over to	o the resident and			investigated immediately per		
	speak to her cl	osely so the resident			abuse protocol. Grievances wi		
	could hear wha	it staff was saying.			be daily by ED/Designee. The		
	The SSA indica	ated she had			DNS and/or designee will cond		
	completed a Re	esident/Family			a staff in-service on abuse, ab prevention, allegations of abus		
		ance Form, dated			and reporting of abuse on May		
		d not followed up on			th , 6 th , 15 th , 2012 and		
	· ·	vith her Supervisor or			ongoing. All potential allegatio		
	ED.				of abuse will be reported timel	y to	
					the Director of Nursing and		
					Executive Director for	_	
	On 4/17/10 ct	12:40 n m the CCA			investigation and reporting per our policy. <b>4. How the</b>		
		12:40 p.m., the SSA			corrective actions will be		
		ied to the Director Of			monitored to ensure the		
		N) office to obtain the			deficient practice will not rec	ur	
		n. The DON indicated			(i.e., what quality assurance		
		ceived the form and			program will be put into plac	e?	
	did not have kr	lowledge of the			To ensure compliance, the DN		
	resident's griev	ance on 2/22/12			Designee is responsible for		
	before 4/17/12	at 11:45 a.m. The			completion of the abuse CQI to		
	form was signe	d by the SSA, but was			weekly x 4 weeks, bimonthly x	12	
		he Director of Social			months, and quarterly until continued compliance is		
					Continued Compilance is		

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Facility ID: 011367

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		155761	B. WIN	G		04/17/	2012
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				2 E TILI			
BROWNS	SBURG MEADOWS	5		BROW	NSBURG, IN 46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Executive Director.			maintained for 2 consecutive quarters. The results of these		
		owledged she had kept			audits will be reviewed by the	COI	
		desk since 2/22/12			committee overseen by the ED		
		lowed up on Resident			threshold of 100% is not achie		
	#80's complain	t.			an action plan will be develope	ed	
					to assure compliance.		
		4 a.m., a review of the					
	facility's policy						
	Prohibition, Rep	•					
	_	olicy and Procedure,"					
	•	2010, provided by the					
	Executive Director indicated the						
	definition of abu	use as, "the willful					
	_	ry, unreasonable					
	confinement, in	itimidation or					
	•	h resulting physical					
	harm or pain or	mental anguish. This					
	includes depriv	ation by an individual,					
	including a care	etaker, of goods or					
	services that ar	re necessary to attain					
	or maintain phy	sical mental or					
	psychosocial w	ell being. This					
	presumes that	instances of abuse of					
	all residents, ev	ven those in a coma,					
	cause physical	harm, or pain, or					
	mental anguish	l. <b>"</b>					
	Point #5 on pag	ge 2 entitled, "Policy					
	and Procedure'	" indicated, "all					
	abuse/allegatio	ns of abuse must be					
	reported to the	Executive Director					
	immediately, ar	nd to the resident's					
	representative	(sponsor, responsible					
	party) within 24	hours of the report.					
	Failure to repor	t will result in					
	<u> </u>				l		

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Event ID: M9H911

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PRINTED: 05/15/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155761	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM 04/	TE SURVEY  IPLETED  17/2012		
	PROVIDER OR SUPPLIER SBURG MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE  2 E TILDEN  BROWNSBURG, IN 46112					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	disciplinary action, up to and including immediate termination.						
	3.1-28(a)						

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Event ID: M9H911

Facility ID: 011367

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A DULL DDVC  00			(X3) DATE SURVEY COMPLETED		
		155761	A. BUIL		<del></del>	04/17/201	
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		2 E TILI			
BROWN	SBURG MEADOWS	3			NSBURG, IN 46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	MPLETION
F0241	483.15(a)	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!)		DATE
SS=E	DIGNITY AND R INDIVIDUALITY The facility must in a manner and maintains or enh	promote care for residents in an environment that ances each resident's dignity all recognition of his or her	F024	1	F241	05	5/17/2012
	Rased on ohse	rvation, interview and					
		•			1. What corrective actions will		
		the facility failed to			be accomplished for those		
		ts and their belongings			residents found to have been affected by the deficient practice?		
		ith respect and dignity			anected by the dencient practice:		
	related to resid	ents wandering into			Resident #44 and #280 were		
	rooms and goir	ng through belongings			reported to have entered other		
	and staff to res	ident interaction. This			resident's rooms and went through		
	affected 7 of th	e 51 residents living on			their personal belongings. Resident #44 was discharged from the facility	<b>I</b>	
	the 400 unit at	the time of survey.			1/26/12 and would not have been		
	This affected R	esidents # 's 66, 3, 54,			present during the survey to have		
		75 and involved			been observed doing anything. No		
	Resident # 's 4				identifying information was left for resident #280. The facility is aware	a	
		1 4114 200.			of another resident with dementia		
	Findings Includ	le:			who does wander and her familyha	s	
		C.			moved them to a secured dementia		
	4) 5				unit.		
	'	terview with Resident			Employee #1, who allegedly whistle	d	
		at 2:45 p.m., Resident			at a resident, was stopped by the	<u> </u>	
	#66 indicated the	hat other residents			surveyor and Employee #1 stated		
	(Residents #44	4 and 280) wander into			she was not whistling. Resident #27	5	
	her room any ti	me they want and at			when interviewed states they does		
	times went thro	ough her belongings.			not recall anyone whistling at them		
	She indicated t	hat there are a couple			A meeting was held with Resident #		
		at wander from room to			80. When asked if she has ever been		

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Event ID: M9H911

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155761	B. WIN			04/17/2012
NAME OF I	PROVIDER OR SUPPLIER	· {	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				2 E TIL		
BROWN:	SBURG MEADOWS	<u> </u>		BROW	NSBURG, IN 46112	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
1710		one resident (Resident		1710	treated badly here she states "no"	
	#44) is constar	,			However, further discussion revea	
	1	•			she thinks all males that work here	
		ndicated the facility			are here for sexual reasons. We ha	
		the issue but were not			added to her care plan she is not to	0
	able to.				have male caregivers if at all possible. Due to the fact this	
					resident had not informed us of ar	пу
	2) During an interview with Resident				prior concerns with this issue, she	
	#3 on 4/10/12	at 1:30 p.m., Resident			was educated on how to report an	у
	#3, indicated th	nere are people who			complaints that she has. Resident	
	have dementia	that are free to roam			states sometimes she "just gets these things in her head." She has	
	around the buil	lding and will wander			been referred for counseling and	
		Resident #3 indicated			psychological evaluation on this	
		ularly bothered by			issue. During care plan resident	
	· ·	pecause she has "tore			could not think or describe any	, d
					other employee she is fearful of ar states she likes living here. Her	iu
		belong to her such as			psychological evaluation showed	
	1	zles, and she has			diagnosis of dementia, parnoid	
	1	on to the floor when			personality disorder, rule out	
	she has roame	ed into the room.			delirium, and history of false	
	Resident #3 als	so indicated that			allegations.	
	sometimes she	e is able to move				
	Resident #44 's	s wheel chair out of the				
	room, but that	Resident #44 can be			2. How other residents having	
	very strong and	d sometimes won't			the potential to be affected by the same deficient practice will be	=
	1 ,	nt #3 also indicated			identified and what correction	
		is "scary" when			actions will be taken?	
		oams into her room				
		s strong and does not				
		•			All residents have the potential to	be
		is doing. Resident #3			affected. The DNS and/or designee	<u> </u>
		have been times when			will conduct a staff in-service on	
	Resident #44 h	nas roamed into her			dignity on May 5 th, 6 th, 15 th,	
					2012 and ongoing. The facility will	

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Event ID: M9H911

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	BUILDING COMPLETED		
		155761	B. WIN			04/17/2012
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			2 E TILI		
BROWNS	SBURG MEADOWS	3		BROW	NSBURG, IN 46112	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	· ·	norning hours while			still continue to offer all resident	
	Resident #3 an	d her roommate are			stop signs for their doors or motion detectors for their rooms. Every	
	asleep and it is	"scary to wake up			month in resident council, we will	
	with someone v	wandering in your room			ask residents again if they have any	
	and going throu	ugh your stuff. "			concerns regarding dignity.	
	1	dicated there was a				
		ident #44 hit her on the				
					3. What measures will be put	
		I there are times she			into place or what systemic change	s
		and other residents			will be made to ensure that the	
	that try to remo	ve her from a place			deficient practice does not recur?	
	she doesn't bel	ong. Resident #3				
	indicated that F	Resident #280 does				
	wander into he	r room often; however,			The DNS and/or designee will	
	she had the mo	ost "problems" with			conduct a staff in-service on dignity	
		Resident #3 indicated			on May 5 th , 6 th , 15 th , 2012 and	
		gested a door bell or			ongoing. The facility will still	
	' '				continue to offer all resident stop signs for their doors or motion	
		t on the door to try to			detectors for their rooms. Every	
	·	that wander out of the			month in resident council, we will	
	rooms, but they	didn't do it. Resident			ask residents again if they have any	
	#3 also indicate	ed the facility told the			concerns regarding dignity. Facility	
	residents "that	could be any of us			will address all concerns	
	someday" and	that the residents that			immediately. Residents will be encouraged to voice any concerns to	,
		the building have the			their customer service	´
	right to do so.				representative or any other staff.	
	3) During an in	terview with Resident				
	l '	at 9:20 a.m., Resident			4. How the corrective actions	
					will be monitored to ensure the	
		here are people who			deficient practice will not recur	
		m around and enter			(i.e., what quality assurance	
	her room. She	indicated that she had			program will be put into place?	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	00	(X3) DATE COMPL		
ANDILAN	or correction	155761		LDING		04/17/		
		.557.01	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	\$ 17 · 17		
NAME OF F	PROVIDER OR SUPPLIER			2 E TILI				
BROWN	SBURG MEADOWS	3			NSBURG, IN 46112			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE	
		elongings gone through						
	•	4 who enters her room						
	-	sis. Resident #54			To ensure compliance, the Social			
	indicated she is not afraid of the			Service Director/Designee is responsible for completion of the				
		vander into her room;			dignity CQI tool, weekly x 4 weeks,			
		lly bothered her to			bimonthly x 2 months, and quarterl	У		
		own room and see			until continued compliance is maintained for 2 consecutive			
		going through her			quarters. The results of these audits	5		
	·	ent #54 indicated the			will be reviewed by the CQI			
	facility did not try to fix the situation				committee overseen by the ED. If	n		
	<u> </u>	nts that wander into			threshold of 100% is not achieved a action plan will be developed to	11		
		esident #54 indicated			assure compliance.			
		old their doctors say						
		to wander around, so						
		deal with it and that it						
	-	f us some day. "						
	Could be ally of	lus some day.						
	,	servation on the						
	afternoon of 4/	11/12, and in the						
	presence of the	e 400 Hall Unit						
	Manager, Resid	dent #129 was seen						
	pushing Reside	ent #44 in a wheel						
	chair up the ha	ll way to the nurses						
	station. Reside	ent #129 looked at the						
	Unit Manager a	and stated "she was in						
	our room" and	turned to walk back to						
	her room. Res	ident #129 and #123						
	are room mates	s and Resident #44						
	was taken out o	of their room to the						
	nurses station l	by Resident #129.						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155761	ĺ	LDING	NSTRUCTION  00	(X3) DATE COMPI <b>04/17</b>	ETED
	PROVIDER OR SUPPLIER SBURG MEADOWS			2 E TILE	DDRESS, CITY, STATE, ZIP CODE DEN ISBURG, IN 46112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
TAG	5) During an obat 12:40 p.m., E (Certified Nurse observed whist who was sleep attention and yeshe was walking resident "Hey [I #275] it's time for the she had been to male staff memindicated "Som are rough." She believes one made stage he her the stage of the she had because he her the stage of the stag	eservation on 4/17/12 Employee #1, CNA es Assistant) was ling at Resident #275, ing, as to get her elled to the resident as g quickly past the Name of Resident for lunch!"  2 at 02:24 p.m., an Resident #80 indicated reated roughly by a aber. Resident #80 etimes the male CNAs e indicated she ale aide fondled her ld her too closely to his		TAG	DEFICIENCY)		DATE
	assisted in transbed to her whe indicated one C room and indicated, "The toilet stops up.' The resident in didn't introduce coming into her	y blame me when the					

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	OF CORRECTION	IDENTIFICATION NUMBER:  155761	A. BUII B. WIN	DING	00	COMPLETED 04/17/2012	
	PROVIDER OR SUPPLIER		P	STREET A	ADDRESS, CITY, STATE, ZIP CODE DEN NSBURG, IN 46112		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE .	(X5) COMPLETION DATE
mo	asked who they do you want to to get me in tro also indicated to behind her and her wheelchair know who they	were, indicating "Why know? Are you going uble?" The resident he staff walk up start pushing her in without letting her are.					Bitts
	specific names concerns are do often was made an hour after us assistance. She shift was the wonights when no her all night and	as unable to identify of staff and indicated uring all shifts and she to wait 45 minutes to sing her call light for e indicated the night orst and there were one came to check on d she would be wet, intinent, up to her neck					
	review of the Q Set, dated 3/11 Resident #80's Mental Status [I was 14 of a total	2:45 p.m., a record uarterly Minimum Data /12, indicated Brief Indicator of BIMS] Cognition Score al of 15 indicating a gnitive function.					
	with Resident # were rude and o providing care f all staff were ru she indicated, "	8:17 p.m., an interview 80 indicated the staff disrespectful when for her. When asked if de and disrespectful Just some of them. disrespectful. Some of					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		155761	A. BUII B. WIN	LDING	<del></del>	04/17/	
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2 E TILI	DEN		
BROWN	SBURG MEADOWS	3		BROWN	NSBURG, IN 46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		are really rough and I		TAG	DEFICIENCE)		DATE
		at. They rush me. One					
		n he picks me up, he					
		ose and too tight. I					
		ndling." When asked					
	"Do you feel the	e staff treats you with					
		nity? For example,					
		the time to listen to					
		aff helpful when you					
	•	nce?", her response					
	was, "No".						
	During an inter	view with the Executive					
	_	on 4/12/12 at 2:30					
	p.m., she indica	ated that some					
	residents who	were cognitively intact					
	• •	ce" against those who					
		. She indicated that					
		ho are cognitively					
		he facility should					
		idents who are not ct. The E.D. indicated					
		of wandering residents					
		ght up in resident					
		gs before and that she					
	,	the residents in the					
	meetings they	do have the right to					
		could all be in that					
	position some						
		icility offered stop					
	_	ell alarms to alert when					
	the residents d	was coming in and					
	i ine residents di	ecimea.					

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PRINTED: 05/15/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155761	A. BUII	LDING	00	COMPLETED 04/17/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2 E TILI			
	SBURG MEADOWS	}			NSBURG, IN 46112		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
		Council Agenda" for					21112
		ewed on 4/13/12 at					
		agenda confirmed					
		ndicated at the time of					
		indicated that the					
		ned to put up a stop					
	sign or door ala						
	_						
	3.1-3(t)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIHI	DDIC	00	COMPL	ETED
		155761	A. BUII B. WIN			04/17/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
BROWNS	SBURG MEADOWS		2 E TILDEN BROWNSBURG, IN 46112				
(X4) ID		TATEMENT OF DEFICIENCIES	T .	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		DATE
F0249	483.15(f)(2)						
SS=C	( , ( ,	IS OF ACTIVITY					
	PROFESSIONAL						
		ogram must be directed by a					
		ional who is a qualified					
	•	eation specialist or an					
	•	ional who is licensed or					
		licable, by the State in which					
		s eligible for certification as a					
	•	eation specialist or as an ional by a recognized					
	•	on or after October 1, 1990;					
		f experience in a social or					
		gram within the last 5 years, 1					
		-time in a patient activities					
	program in a hea	alth care setting; or is a					
	· ·	tional therapist or					
		rapy assistant; or has					
	•	ning course approved by the					
	State.		F02	40			05/15/0010
			F02	49			05/17/2012
	Based on recor	d review and			<u>F249</u>		
	interview, the fa	acility failed to ensure			1 Compositive action(s) to be		
	the Activity Dire	ector had completed a			<ol> <li>Corrective action(s) to be accomplished for those residents</li> </ol>		
	•	course prior to taking			found to have been affected by the		
		d directing the activity			deficient practice.		
	•	had the potential to			acserie praesioci		
		nts in the facility.			No specific residents were identified	l	
	anect an reside	into in the facility.			in this deficient practice.		
	Finalina: - ! ! !				·		
	Findings includ	e.			2. How other residents having		
					the potential to be affected by the		
	•	v of employee records			same deficient practice will be		
	on 4/16/12 at 1	:00 p.m.,			identified and what corrective		
	documentation	was not available			action(s) will be taken.		
	regarding the tr	raining of the Activity					
	Director.	-			All residents have the potential to be		
					affected by this deficient practice. A	S	
	Further informa	ition was requested			a corrective action, the employee		
		and in was requested			currently holding this position will		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED
		155761	B. WIN			04/17/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	₹				
DDOMAN		2		2 E TILI		
BROWNS	SBURG MEADOWS	•		BROWI	NSBURG, IN 46112	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	regarding docu	mentation of the			have completed a State-approved	
	Activity Director's training from the				activity director course by May 17,	
Administrator on 4/16/12 at 2:30 p.m.					2012.	
	/ tarriiriiotrator c	71 -17 107 12 dt 2.00 p.m.				
	Duminan an intan				3. What measures will be put	
	_	view with the Activity			into place or what systemic change	s
		6/12 at 2:15 p.m., she			will be made to ensure that the	
	indicated she v	vas currently enrolled			deficient practice does not recur.	
	in a state appro	oved course for Activity				
	Directors. She	provided			In the future, the activities program	
	documentation	at this time to show			will be directed by a qualified	
		ed in this course.			professional. This will be monitored	
	one was on on	od in this source.			by our Human Resource Director to	
	In an intancious	with the Downell			be sure they have the necessary	
		with the Payroll			qualifications. The HR Director has	
		7/12 at 4:00 p.m., she			been inserviced on the correct	
	indicated the A	ctivity Director started			qualifications for an Activity	
	this position on	4/9/12. She indicated			Director.	
	she had been	part of the			l	
	Housekeeping	Department prior to			4. How the corrective action(s)	
		the Activity Director.			will be monitored to ensure the	
		and reducing Direction			deficient practice will not recur, i.e	"
	During on inter	wiow with the			what quality assurance program	
	During an inter				will be put into place.	
		on 4/16/12 at 3:45 p.m.,			Any new director hired into this	
		knowledge of the			position will meet State and Federal	
	qualifications n	eeded by the Activity			requirements upon hire. Upon hire,	
	Director, but sh	ne had spoken with a			this person must be a: qualified	
	consultant at h	er corporate office and			therapeutic recreation specialist,	
		e employee, after			licensed/registered activities	
	_	the position of Activity			professional, occupational therapist	
	_	year to complete a			occupational therapy assistant, or	, l
		-			someone who has completed a	
	state approved	Course.			State-approved course.	
	3.1-33(e)					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155761	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 04/	TE SURVEY MPLETED 17/2012			
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 2 E TILDEN BROWNSBURG, IN 46112						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE			

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Event ID: M9H911

Facility ID: 011367

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155761			(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL <b>04/17</b> /	ETED
	PROVIDER OR SUPPLIER		B. WING	STREET A	DEN NSBURG, IN 46112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0353 SS=E	CARE PLANS The facility must to provide nursin attain or maintair physical, mental, of each resident, assessments and The facility must sufficient number types of personn provide nursing of accordance with  Except when was this section, licer nursing personne Except when was this section, the filicensed nurse to each tour of duty Based on obse the facility failed nursing staff to residents. This sampled reside 132 residents re This affected R 123, 66, 3, 54,  Findings Includ  1. During an in 10:20 a.m., with in the presence	ived under paragraph (c) of facility must designate a serve as a charge nurse on rvation and interview, d to provide sufficient meet the needs of all affected 9 of 40 ents in a total sample of esiding in the facility. esident #'s 15, 80, 24, 104, and 129.	F035	3	F 353 1. Corrective action(s to be accomplished for those residents found to have been affected by the deficient practice. There is adequate s to provide necessary care and services to all residents. A resident council meeting will be held, with any residents who we to attend, regarding their concerns surrounding sufficient staffing. In this meeting we will discuss how the building is staffed, expectations of staff at ways they can approach us if the have a staffing concern. Reside #123 has indicated she would to be checked on more often definition.	taff e vish nt het chey ent like	05/17/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155761	B. WIN	G		04/17/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DDOMAN				2 E TILI		
BROWN	SBURG MEADOWS			BROWN	NSBURG, IN 46112	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
TAG				TAG	to her condition, and the nurse	DATE
	1	s not have "enough dents indicated there			aide assignment sheet was	
		CNA's ( Certified			updated 2. <b>How other</b>	
		to help all residents get			residents having the potentia	ıl
		they need, including			to be affected by the same	
	themselves. F	-			deficient practice will be identified and what corrective	۱
		ince she and her room			action(s) will be taken. All	
		independent than			residents have the potential to	
		, the nurses aides do			affected by this deficient practi	
		em as often as they			A nursing schedule and staffin ratio are reviewed daily. The	g
	should because	•			DNS/Designee is responsible to	for
		y residents that are no			ensuring adequate and sufficie	
		dent. Resident #123			staff to provide care to all	
		as trouble breathing			residents. The 400 hall nurse a assignments have been	aide
	sometimes and	would like to be			reassigned according to reside	ents
	checked on mo	re often.			needs. 3. What measures	
					will be put into place or what	
	During an obse	ervation on the			systemic changes will be ma	de
	afternoon of 4/	11/12, and in the			to ensure that the deficient practice does not recur. A	
	presence of the	e 400 Hall Unit			nursing schedule and staffing	
	·	dent #129 was seen			ratio are reviewed daily. The	
		ent #44 in a wheel			DNS/Designee is responsible to	
	l '	Il way to the nurses			ensuring adequate and sufficient staff to provide care to all	ant
	· ·	ent #129 looked at the			residents. The 400 hall nurse a	aide
					assignments have been	
		and stated "she was in			reassigned according to resident needs. 4. How the correction	
		turned to walk back to			action(s) will be monitored to	-
	her room. Res	ident #129 and #123			ensure the deficient practice	
	are room mates	s and Resident #44			will not recur, i.e., what quali	
	was taken out	of their room to the			assurance program will be pu	ut
	nurses station by Resident #129.			into place. To ensure compliance, the DNS/Designer	e is	
					responsible for completion of t	
					sufficient staffing CQI tool, wee	ekly
	2. During an in	terview on 4/11/12 at			x 4 weeks, bimonthly x 2 mont	hs,
	l		1		l e e e e e e e e e e e e e e e e e e e	ı

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155761			LDING	onstruction 00	(X3) DATE ( COMPL <b>04/17</b> /	ETED	
	ROVIDER OR SUPPLIER		•	2 E TILI	ADDRESS, CITY, STATE, ZIP CODE DEN NSBURG, IN 46112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	2:45 p.m., with indicated there to provide residenced.  3. During an in #3 on 4/10/12 a indicated that the staffed every determined they are very signed they are very signed to the 400 unit even have a very large work them very staffed." Residence are a lot of that require total staff.  4. During an in #54 on 4/11/12 indicated that the for assistance of the indicated that the for assistance of the indicated that require nursing staff.  5. During an in #104 on 4/10/1 indicated that is short staffed.	Resident #66, she are not enough CNA's lents with what they terview with Resident at 1:30 p.m., she he facility is "short ay." She indicated hort of nurses aides. Ited there is meone new working on ery day because "they ge turn over" and "they hard and short dent #3 also indicated of residents on the unit al care from nursing terview with Resident at 9:20 a.m., she he facility is very short			and quarterly until continued compliance is maintained for a consecutive quarters. The res of these audits will be reviewed by the CQI committee overset by the ED. If threshold of 1000 not achieved an action plan will be developed to assure compliance.	ults d en % is	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155761		LDING	NSTRUCTION 00	(X3) DATE COMPI <b>04/17</b>		
	PROVIDER OR SUPPLIER		2 E TILI	DEN NSBURG, IN 46112	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	E	(X5) COMPLETION DATE
	gets the help the need it.	ney need when they				
	#54 on 4/16/12 #54 was visibly she was very u was no one to a morning. She advocate arour it the do-it-your said "They are around here I h times this morn have my clothed there is no help.					
	a.m., she indicatis normally con	view with LPN on 4/16/12 at 11:00 ated that Resident #54 tinent of bladder and ne needs to use the				
	of Nursing (DO a.m., they indict the 400 Hall (w interviewed resturing daytime They explained survey, there w residing on the	view with the ordinator and Director N) on 4/17/12 at 11:00 rated they usually staff here all residents rided) with 4 CNA's and evening shift. I that at the time of the vere 51 residents unit. They did indicate to replace any shift or				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE ( COMPL		
1111212111	or conditions	155761		LDING		04/17/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			2 E TILI			
BROWN	SBURG MEADOWS	3			NSBURG, IN 46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	alled off." The DON					
	· •	eople who were					
		d a male CNA on their					
	•	d not want to be taken					
	care of by a ma						
		uld have to wait for					
		e indicated that they					
		an help for transfers, are and that's why the					
		d have to wait for a					
	female CNA.	Thave to wait for a					
		1.2.25					
	7. On 4/9/12 a	•					
		Resident #15 indicated,					
		d help going to the nave to wait awhile.					
	· ·	ong while. When I'm					
		ped I put on my light					
		or someone to come					
		ady and get in bed. I					
		hile for that, too."					
	asaany wan aw	Thic for that, too.					
	8. On 4/10/12	at 2:24 p.m., an					
	interview with F	Resident #80 indicated					
	she was routine	ely made to wait 45					
	minutes to an h	our when she used					
	her call light to	request assistance.					
		e to identify specific					
	names of staff	and indicated					
	concerns are d	uring all shifts. She					
		ght shift was the worst					
		nights when no one					
		on her all night and					
	she would be w	•					
	incontinent, up	to her neck by					
	morning.						

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AND PLAN O		IDENTIFICATION NUMBER:  155761		LDING	00	COMPL 04/17/	ETED
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
BROWNS	BURG MEADOWS				NSBURG, IN 46112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	9. On 4/11/12 a interview with F "Sometimes I h before someonme." She indicate	at 10:00 a.m., an Resident #24 indicated ave to wait awhile e comes in to help ated all shifts were at to her call light.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155761	B. WING		04/17/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		2 E TIL		
BBOWNIG	SBURG MEADOWS			NSBURG, IN 46112	
BROWN	SBURG MEADOWS	9	BROW	N3B0KG, IN 40112	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0520	483.75(o)(1)				
SS=E		EE-MEMBERS/MEET			
	QUARTERLY/PI	_ANS			
	-	aintain a quality assessment			
		ommittee consisting of the			
		ig services; a physician			
		e facility; and at least 3 other			
	members of the	racility's starr.			
	The quality asse	ssment and assurance			
		s at least quarterly to identify			
		ect to which quality			
		assurance activities are			
		develops and implements			
	-	s of action to correct			
	identified quality				
		ecretary may not require			
		records of such committee			
	•	s such disclosure is related to			
		of such committee with the			
	requirements of	this section.			
	Cood faith attain	pts by the committee to			
		ect quality deficiencies will			
		basis for sanctions.			
			F0520		05/17/2012
		view, record review,	10320	520	03/17/2012
		n, the facility failed to		<u>520</u>	
	identify and imp	olement a plan of		What corrective actions will	
	action for the ic	lentified concerns of		be accomplished for those	
	resident dignity	related to wandering		residents found to have been	
		ndequate staffing. This		affected by the deficient practice?	
		) sampled residents in		and the deficient practice:	
		of 132 residents			
	•	facility. Resident #s		A QA process has been initiated to	
	123, 129, 66, 1	04, 54, 15, 80, 24, 3.		identify and implement a plan of	
				action for the residents' concerns	
				related to dignity and staffing.	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		155761	B. WIN			04/17/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		2 E TILI			
DD (WN)	SBURG MEADOWS				NSBURG, IN 46112		
BROWN	SBUNG WEADOW	3		BROW	N3BUKG, IN 40112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings Includ	le:					
	1. During an interview on 4/10/12 at 10:20 a.m., with Resident #123, and						
					2. How other residents having		
	1	-			the potential to be affected by the		
		e of Resident #129,			same deficient practice will be		
		indicated that they feel			identified and what correction		
		does not have "enough			actions will be taken?		
	help." The res	idents indicated there					
	are not enough	n CNA's (Certified					
	Nurses Aides)	to help all residents get			l.,, ., ., ., ., ., ., ., ., .,		
	l '	they need. Resident			All residents have the potential to b	е	
		that since she and her			affected. A QA process has been		
					initiated to identify and implement	a	
		more independent than			plan of action for the residents'		
		, the nurses aides do			concerns related to dignity and		
		nem very much			staffing.		
	because they a	are so overwhelmed by					
	residents that a	are no longer					
	independent.				3. What measures will be put		
	·				into place or what systemic change	ic .	
	2 During an in	terview on 4/11/12 at			will be made to ensure that the	•	
		Resident #66, she			deficient practice does not recur?		
	· •				dentient practice does not recur.		
		are not enough CNA's			In addition to our regularly		
	l '.	dents with what they			scheduled QA topics, the resident		
	need.				council will be asked prior to any QA	Ą	
					meeting to see if they have concern		
	3. During ant ir	nterview with Resident			regarding staffing.		
	#104 on 4/10/1	2 at 2:30 p.m., she					
		she feels like the facility			4. How the corrective actions		
		-			will be monitored to ensure the		
	is short staffed in regards to the CNA's and that not every resident				deficient practice will not recur		
		•			(i.e., what quality assurance		
	gets the help they need when they				program will be put into place?		
	need it.						
	4. During an ol	oservation of Resident					
	#54 on 4/10/12	2 at 9:50 a.m., Resident			A CQI tool for dignity and sufficient		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE : COMPL		
THIE TEAT	or condition	155761		LDING		04/17/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L,	
NAME OF F	PROVIDER OR SUPPLIER			2 E TILI			
BROWN	SBURG MEADOWS	3			NSBURG, IN 46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		y upset and indicated		IAG	staffing has been initiated and will		DATE
		pset there was no one			be completed by Executive Director		
	•	rlier that morning.			and/or designee. This tool will be		
		e need an advocate			completed 3 times a week for 2		
	around here, I'r	m gonna' call it the			weeks, weekly x 4 weeks then monthly x 3 months. This CQI tool		
	do-it- yourself h	nospital!" She also			will be reviewed through the Qualit	у	
	,	so short handed			Assurance team monthly.		
		ave been wet two					
		ing and have had to					
		s changed because					
	there is no help	).					
	During an inter	view with I PN					
	_	on 4/10/12 at 11:00					
		ated that Resident #54					
	is normally con	tinent of her bladder					
	and knows whe	en she needs to use					
	the restroom.						
	5. On 4/9/12 a	t 3:35 p.m., an					
	interview with F	Resident #15 indicated,					
	"When we need	d help going to the					
	•	nave to wait awhile.					
		ong while. When I'm					
	, ,	ped I put on my light					
		or someone to come					
		ady and get in bed. I					
	i usualiy wall aw	hile for that, too."					
	6. On 4/10/12 a	at 2:24 p.m., an					
		Resident #80 indicated					
		ely made to wait 45					
		nour when she used					
	her call light to	request assistance.					
	She was unable	e to identify specific					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155761		LDING	NSTRUCTION 00	(X3) DATE : COMPL <b>04/17</b> /	ETED	
	PROVIDER OR SUPPLIER		2 E TILI	DDDRESS, CITY, STATE, ZIP CODE DEN NSBURG, IN 46112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated the ni and there were	uring all shifts. She ight shift was the worst nights when no one on her all night and vet, from being				
	interview with F "Sometimes I h before someon me." She indica	at 10:00 a.m., an Resident #24 indicated lave to wait awhile e comes in to help lated all shifts were d to her call light.				
	#66 on 4/9/12 a #66 indicated to (Residents #44 her room any to times went through She indicated to of residents that	at 2:45 p.m., Resident hat other residents 4 and 280) wander into me they want and at bugh her belongings. hat there are a couple at wander from room to one resident (Resident atly wandering.				
	#3 on 4/10/12 a #3, indicated th have dementia around the buil	terview with Resident at 1:30 p.m., Resident here are people who , that are free to roam ding that will wander Resident #3 indicated				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE COMPL		
AND PLAIN	OF CORRECTION	155761		LDING	00	04/17/	
		100701	B. WIN			04/17/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BROWNS	SBURG MEADOWS	3		2 E TILI BROWN	NSBURG, IN 46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	that she was pa	articularly worried					
		#44 because she has					
		that belong to her,					
		and puzzles, and that					
		ed things on the floor					
		oamed into the room.					
		so indicated that					
		is able to move					
		wheelchair out of the					
	•	Resident #44 can be					
	, ,	I sometimes won't					
		nt #3 indicated that at					
		y" when Resident #44					
		o her room because					
	_	nd doesn't know what					
	_	Resident #3 indicated					
		been times when					
		nas roamed into her					
	•	orning hours while					
		d her roommate were					
		is "scary to wake up					
		vandering in your room					
	and going throu	0 1					
		dicated there was a					
		ident #44 hit her on the					
		that there are times					
	she will resist s						
		ry to remove her from					
		esn't belong. Resident					
		at Resident #280 does					
		r room often; however,					
		ost "problems" with					
		Resident #3 also					
		ne facility suggested a					
	doorbell or stop	sign to put on the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155761			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	LETED	
		155761	B. WIN				/2012
	PROVIDER OR SUPPLIER			2 E TILI	ADDRESS, CITY, STATE, ZIP COD DEN NSBURG, IN 46112	Е	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	door to try and wonder out of r do it. Resident the facility told could be any of the residents the building have the 10. During an afternoon of 4/r presence of the Manager, Reside chair up the hastation. Resided Chair up the hastation in the resident Chair up the hastation in the hastation in the resident Chair up the hastation in the hastation in	keep residents that ooms, but they didn't #3 also indicated that the residents "that "us someday" and that hat wander around the he right to do so.					
	issue of wande	ring residents had					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		(X3) DATE SURVEY  COMPLETED		
ANDILAN	155761	A. BUILDING	00	04/17/2012		
	100701	B. WING		07/11/2012		
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
BROWN	SBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112				
			I	075		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (FACH DEFICIENCY MUST BE BEDGEDED BY FULL)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE		
mo	been brought up in resident council	1110		BATE		
	meetings before and that she did					
	indicate to the residents in the					
	meetings they do have the right to					
	wander and we could all be in that					
	position someday. The E.D. indicated					
	the facility offered stop signs or doorbell alarms to alert when another					
	person was coming in and the					
	residents declined.					
	The "Resident Council Agenda" for					
	6/2/11 was reviewed on 4/13/12 at					
	9:30 a.m. The agenda confirmed					
	what the E.D. indicated at the time of					
	the interview.					
	During an Interview with the					
	Executive Director (ED) on 4/17/12 at					
	11:30 a.m., indicated that deficiencies					
	in the areas of adequate staffing were					
	discussed more in the reference of					
	time ratio, and resident dignity with					
	the issue of wandering residents had					
	been brought up in resident council					
	meetings before, but had not been					
	brought to the Quality Assurance					
	Committee since January 2012. It					
	was also indicated that the QA/A					
	1					
	committee had not developed or					
	implemented a plan of action to					
	correct the indicated deficiencies.					
	3 1 52(b)(2)					
	3.1-52(b)(2)					

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		IDENTIFICATION NUMBER:  155761	A. BUILDING  B. WING	00 	COMPLETED 04/17/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2 E TILDEN  BROWNSBURG, IN 46112			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	

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